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NURSING: THE ART, SCIENCE AND VOCATION IN EVOLUTION

Also in this issue:

Report of the Southern Asia Regional Consultation on The Christian Understanding of Health, Healing and Wholeness. New Delhi, India, 25-29 August 1980.

TO YOU—OUR READERS AND FRIENDS—
AND YOURS...

WE WISH A TIME OF REJOICING AND HAPPINNESS TOGETHER DURING THIS SEASON IN WHICH WE CELEBRATE THE COMING OF CHRIST,

AND FOR THE NEW YEAR, MANY BLESSINGS—
HOPES FULFILLED, PLANS REALIZED, RECONCILIATION EFFECTED,
WHOLENESS RESTORED AND PEACE FOUND.

The commissioners and staff of the Christian Medical Commission.

1981

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NURSING: THE ART, SCIENCE AND VOCATION IN EVOLUTION

by R. Nita Barrow, RN RM*

INTRODUCTION

The goal, formulated by the World Health Organization (WHO) in September 1978, of "Health for All by the Year 2000", is one which has achieved, if not universal acclaim, at least a large measure of recognition from the nations and governments of the world. Whether the vast majority of the world's people who, it is intended, are to benefit from the attainment of this goal — the 80-85% of the world's population who live in rural areas or the margins of large cities — have ever heard of it, is questionable. For them, health most often means the absence of seriously debilitating disease or disability.

If disease manifests itself and functions are impaired, to whom do they turn? Not, as is commonly believed in the more affluent or developed nations, to a health facility or a doctor. In this situation, the majority of the world's population today, as they have done from time immemorial, turn to a neighbour or other person known to be engaged in the art of healing. This person may be called a nurse or healer or have no official designation at all. What is more important is that he or she is consulted by the community in times of need and does undertake the functions of caring and even curing — functions usually designated as "nursing".

What does the term "nursing" mean? Does it relate exclusively to the concept of sickness? Over one hundred years ago, Florence Nightingale in her *Notes on Nursing* stated: "Nursing... has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet... the proper selection of diet..."[1] With these and similar words, it seems she was clearly making another connection — between nursing and the protection/promotion of health.

Dictionary definitions of the verb "to nurse" vary quite widely. Some of the synonyms given are:

> to cherish, cultivate, foster, nurture, feed, advance, humour, indulge, pamper, promote, or
>
> to check, hold back, retard, slow, or
>
> to minister (to), care (for), mother (serve), wait (on).

Many of the above definitions relate both to health care and to sickness intervention.

Today, at a time when professionalization of nursing has set standards in many places, while such standardization is being attempted in many others, the diversity of roles and functions which is the origin of nursing is often overlooked. At a recent symposium on the professional practice of nursing, two students described nursing as being "...both intuitive and natural, compassionate and scientific, spontaneous and deliberate, therapeutic and prescriptive."[2] Not an exhaustive definition, but one which identifies the contrasts and diversity of its subject.

HISTORICAL PERSPECTIVE

Before any semblance of training or formal preparation for nursing existed, people simply cared for other people. Within a home, a village or a neighbourhood, mothers or other women in a household or a community, and also people who were believed to possess special gifts and aptitudes for caring and healing, provided such care. The latter, individually, through trial and error, gradually collected a store of healing knowledge which they then passed on, usually to a son or daughter, who carried on their function and service to the community after their death. In many parts of the world, an almost unbroken chain of inherited knowledge links contemporary "tra-

* As a parting gift on the eve of her departure from the Christian Medical Commission (see CMC News section at the back of this issue) CMC Director Nita Barrow has contributed her current thoughts on nursing to this issue of CONTACT.

Ferdinand Enke, Stuttgart, FRG

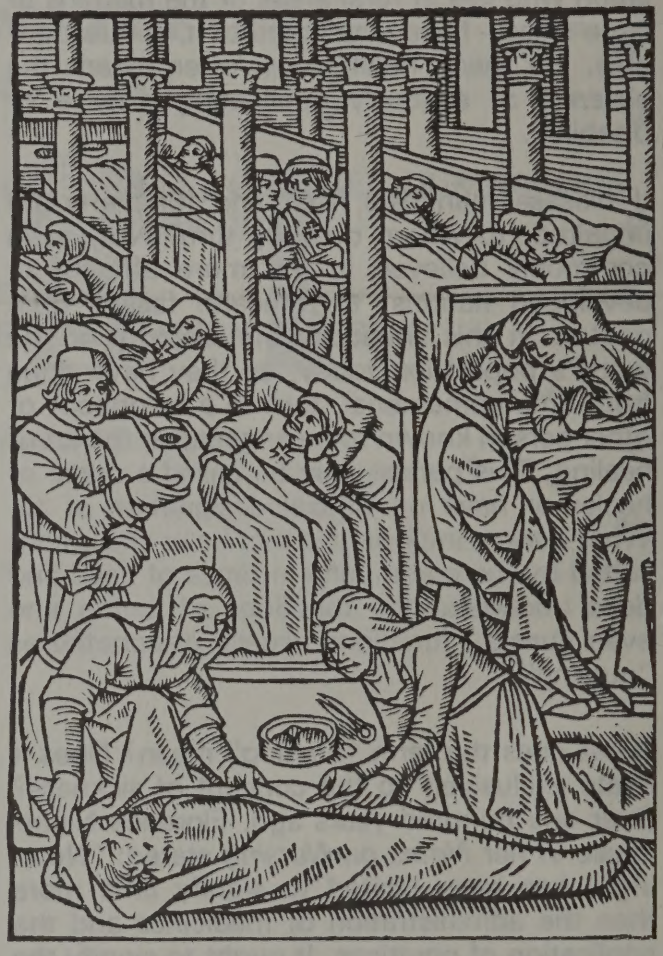
Nursing in ancient Geece: Greek maiden with an emesis basin.

ditional healers" to their counterparts of thousands of years ago. To a certain extent, the same process has been going on, in the same regions, in the community at large, as a slowly evolving body of custom and beliefs about health and sickness, and healing knowledge is passed on from generation to generation.

In time, in other parts of the world, care and healing came to be considered the special responsibility of a priesthood, or other religious groups. In ancient Egypt, for instance, medical functions were combined with priestly ones. The laity continued to play their part, however. The story of the good Samaritan and his application of oil and bandages to the wounds of the traveller is an example of care being given by an "ordinary" person. The Bible contains not only laws relating to health and hygiene, but also descriptions of people caring for the sick, the needy and the elderly. Jesus' admonition to the disciples to go out and preach, teach and heal has been the basis for much of the work of modern missionary health workers.

"Historia Scholastica", 1470

Tobit's wife compounding a remedy from a book of domestic medicine.

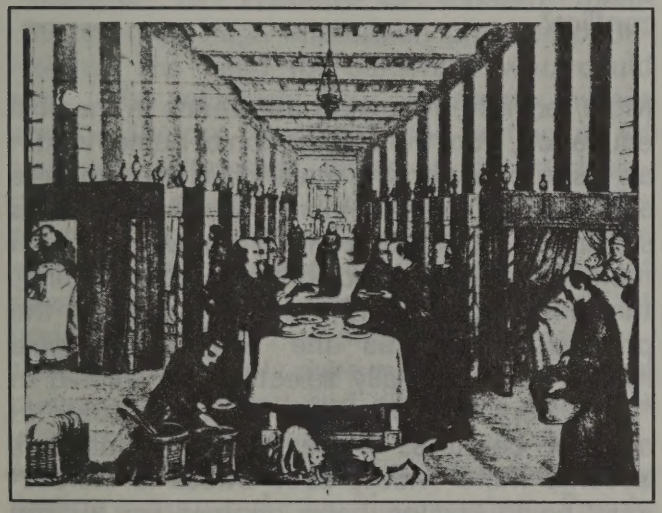


Philadelphia Museum of Art

Medieval hospital interior.

In Europe of the Middle Ages, care of the sick was mainly the responsibility of military and religious orders such as the Knights of Malta and the order of St John of Jerusalem, which are still in existence today, although related to health in a different way. Priests and nuns in

monasteries and convents cared for the sick. "Hospices" (or wayside houses for travellers) were the ancestors of modern hospitals. The care given during this period was based on the accumulated knowledge of herbal and other remedies acquired before the development of the sicentific basis of medicine. At the same time, people who in their own communities acquired knowledge of cures by trial and error, handed them down from one generation to another in the same process as was taking place in regions where no such special orders or groups existed. Such knowledge and caring could be considered as an early manifestation of nursing based on self-care.



Print by Abraham Boss, Bibliothèque Nationale, Paris

The Brothers of St John of God in the Hospital of La Charité, Paris, 17th Century.

In the field of midwifery, the transmission of healing knowledge and practices over the generations is particularly evident. It is here that the person with little formal knowledge or training but some acquired skills still plays a major role. According to the estimates of WHO, over two-thirds of babies born in the world today are delivered by "traditional birth attendants" (TBAs) who go by a variety of names according to the country or continent where they live (*helots, dais, nanas,* etc.) (At the other end of the spectrum and in different regions, we find laws forbidding the delivery of a baby by even a well-prepared graduate nurse!)

Nurses in nineteenth-century Britain were portrayed by Charles Dickens in the characters of the notorious Betsy Prigg and Sairy Gamp. They personify the worst type of character then undertaking nursing. They could mainly be found in dreadful institutions for the care of the poor, the sick and the destitute. Even in better hospitals, drunkenness was said to be common

Sairy Gamp.

among those giving nursing care and, as late as the end of the 19th century, Mrs Agnes Jones of Liverpool Hospital "had to dismiss 35 of her nurses for drunkenness".[3] The kinds of work in which they were engaged and the repulsive nature of some of their assigned tasks can be held responsible not only for such behaviour but also for the quality of the women engaged as "nurses". The caring aspect of nursing was largely replaced by an attitude that saw it as a highly unpleasant and onerous job for which money was the only reward. During the same period, however, excellent work was still being done by the deaconesses and other religious orders.

Against this background of contrasts, the more recent history of nursing begins to emerge. Florence Nightingale's role in "creating" modern nursing is well known. Again, war and religion played their part: it was to an order of deaconesses that she went for such preparation as she received before serving in the Crimea. Her major contribution to nursing was her emphasis on preparation as the key to more effective care of the sick and to maintenance of health, which she later advocated. When tribute is paid to her emphasis on selection and preparation for nursing, the institutional part of this is most often stressed. But, in her own

Bettmann Archive
Florence Nightingale in the hospital ward at Scutari.

(recently reprinted) *Notes on Nursing — What It Is and What It Is Not*, Florence Nightingale clearly stressed the importance of the environment in health. The similarity between her ideas and contemporary dogma on people being involved in their own health care — one of the tenents of current Primary Health Care philosophy — could not be more striking.

Florence Nightingale provided some very clear rules for the preparation of the practitioners of nursing. She not only formulated concepts, but was able to have them tested in a number of training schools, starting with the Nightingale School at St Thomas' Hospital in London, after her triumphant return from the Crimea. And, since the influence of Great Britain spread over a great part of the globe during the closing years of the nineteenth and early years of the twentieth centuries, the "Nightingale nurses" provided leadership and set a pattern which was the basis of nursing education in many regions for many decades to come. Miss Nightingale, through her prolific writings, contributed greatly to this influence.

THE SCIENTIFIC NURSING MODEL — ITS EVOLUTION AND TRANSFER

Since then, nursing preparation, while varying from continent to continent as well as within countries, has become increasingly professionalized. Standards have been set by individual nursing schools as well as being based on law. Yet, despite efforts to standardize, wide disparities in preparation still exist, perhaps in large part due to differences in the understanding of the nurse's role. That programmes vary from degree-level courses offered in academic institutions to the few months' of training offered to a community health worker is a reflection of the different "nursing" roles people are called on to play. Nurses may be required to work within an institution, in teaching or in research, may be using high technology to give sophisticated care, or may be activating a community to care for its own health. All are involved in "nursing". Two fundamentally different streams are nevertheless distinguishable in this variety: professional, technology-dependent nursing in institutions, and the primary care given by simply-trained health workers from, and to, the community in which they live. They need to be examined separately and an attempt made to answer the question: convergence or conflict?

Most recently, following the trends in medical education, from the preparation of nurses within an institution with the main focus on diagnosis and disease management, the emphasis is shifting to preparation within a university, with more liberal arts and scientific content. At first, this trend applied only to the leaders in the profession, just as the early Nightingale nurses were specially selected and trained in "Lady Superintendent" programmes. Now, in affluent countries at least, this trend has become more widespread. Stress is increasingly being laid on basic degrees for a large number of nursing practitioners, and higher degrees for the leadership group. It is often said that the nurse must have this preparation to be able to hold her own (nationally and internationally) in leadership roles as a professional among equals. Stanton states: "Society has been reluctant to recognize the need for academic preparation for nurses, which has resulted in the slow emergence of nurses' professional status".[4] Similarly, Collière remarks, in reference to beliefs and values based on the supremacy of technology: "We have sought to promote nursing practice and especially, to promote the nurse by mastering the more and more complex tools and techniques, thereby imitating physicians and trying in this way to be highly considered and to gain social recognition."[5] There is also the argument that the better the preparation at the basic level, the better quality care the practitioner is able to give. Whether or not this is true remains to be seen. Stanton notes: "Nursing has become multifaceted with increasing responsibilities for nurses. Unfortunately, as nursing knowledge has progressed, nurses have become more and more involved with the tasks they perform rather than the patients they care for."[6]

Many graduates of nursing programmes went to countries where formal preparation of nurses was virtually unknown or only beginning. Up to one and a half decades ago, many went as medical missionaries. In countries which were not yet self-governing or fully independent, they provided the bulk of institutional care, often as part of the services provided by colonizing countries.

Medical needs provided a good entry point to most communities. Systems of traditional medicine and care existed in most of these, but the seemingly magical powders and potions, surgery, injections and sterile prodecures of "scientific" or "Western" or "modern" medicine made a huge impression on local populations. The need for personnel who could assist the relatively few expatriate nurses and/or doctors resulted in the setting up of training programmes, based on imported precepts. The standards thus introduced and the concepts of preparation thus transferred affected local perceptions of the meaning of nursing and healing and health care, and of how people should be prepared for this function. Existing beliefs were overlooked and local customs discredited and discarded. Where it was provided, preparation was based on knowledge and teaching methods from a completely foreign culture and educational system. People were adaptable and learned. The result was a professionalization of nursing that has followed the lead of countries wit different needs.

ANSWERING THE NEEDS

The aim of scientific, professionalized nursing is "quality care", based on "the latest" technology. But, up until the present day and in the foreseeable future, this kind of care can be offered only to a relative few. In the meantime, the health needs of the majority of the world's people are not being met, whether in a developed or a developing country setting. Seventy-five to eighty-five per cent of the populations of developing countries have no access to health care systems which are mostly institution- and urban-based. In developed countries, the response to the health needs of the whole person — the physical, mental, spiritual, social and economic whole — is often neglected in a task-oriented, technology-dependent approach to nursing.

Is the alternative to the ideal of scientific, professional, quality care an interpretation of

WHO/Interfoto MTI
Electrocardiogram examination.

nursing based on empirical knowledge and traditional moral values such as devotion, selflessness, etc.? But "...these values have for so long had such an influence on the concept of care that they prevented new knowledge from being accepted and based nursing practice on noble motivations and blind devotion. This slowed down the evolution of nursing and prevented the growth of nursing science."[7] What, then, is the happy medium between caring, and an over-dependence on technology, between quality care for the few, and "Health Care for All"? How can it be reached?

In both developed and developing countries, the potential for creating and using alternative forms of nursing may most often lie outside the institutional setting. But most nurses are trained in institutions and there learn very little about what nursing outside the walls of the hospital and within the community can mean.

How can nurses adapt to the real needs of people and communities outside the hospital? How can nursing personnel come to understand how other people fit into the health care team, and how can the individual and the community be prepared and enabled to become involved in, and assume responsibility for, their own health care? If ways can be found to meet the needs, how can this knowledge be utilized

to change some of the concepts of care within institutions?

PRIMARY CARE

"To provide basic care, elementary technology is needed which can be easily understood by the population and easily practised by non-specialists. To identify and develop this technology is part of the health revolution of people and of groups."[8]

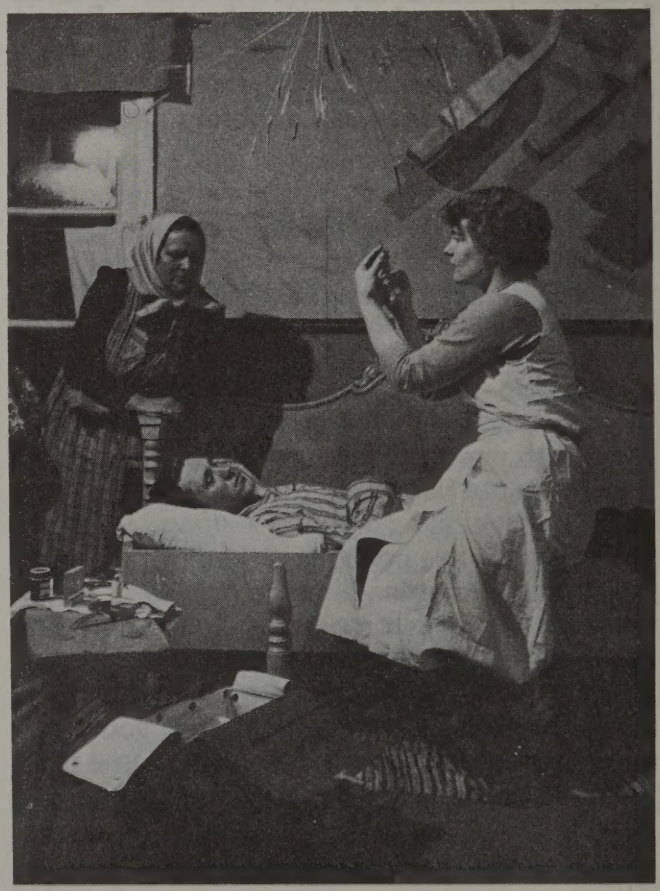
Is the above precept a threat to nurses and nursing? A clue to the answer can perhaps be found in the fact of the discrepancy, in both developing and developed countries, between the demand and the supply, between the numbers of trained nurses available and the expressed need for nursing practitioners. Referring to the scene in the USA, it was recently noted that "In the light of present needs in the health care system, the American Nurses' Association estimates a shortage in hospitals and other segments of the health care field of over 100,000 full-time employed registered nurses by 1982."[9] It is in the "other segments of the health care field" that services can safely and effectively be supplied by personnel other than nurses. And, since nurses *do* have a part to play, of a different nature from that currently accepted, a part based upon different perceptions of their role as well as that of the client and the community, this possible solution to the discrepancy between demand and supply should not be seen as a threat.

The notion of providing basic health care for all rather than only quality care for the few, of responding to people's needs within their physical, mental, social, economic and political context, of transferring elementary health technology to the people and fitting them into the health team, and thus of enabling them to become involved in their own health care, are all elements in the total philosophy of Primary Health Care (PHC). This philosophy has been accepted by most of the member-governments of WHO as a means of bringing health care to a much larger segment of the world's population than now can lay claim to this "privilege".

Restoring the Caring Element

The International Council of Nurses took as its theme for International Nurses' Day in 1980 "The role of the nurse in primary health care", and a recent issue of the *International Nursing Review*[10] highlights this subject. The Canadian Nurses' Association, after examining some of teh strengths and weaknesses of the Canadian health care system, published a study on "Putting Health into Health Care", in which it is stated that "The time is ripe to examine the kind of system that is necessary to motivate and assist Canadians in promoting and maintaining their health."[11] Against a background of legal constraints affecting nursing and the fact that Canada is, technologically, a highly advanced country, the study suggests that the nurse, as a primary care worker, can help to overcome the deficiencies in the present health care system. The goals may be different to those of countries which have not yet developed their health facilities to the same degree as Canada, but Primary Health Care is nevertheless seen as a need.

"While it is important to recognize the achievements of the curative programmes and facilities within the past decade, it is important now to look at ways of reducing the need for their use. By capitalizing on the achievements, new, effective and economical modes of care can be developed to prevent illness, the essential step towards a health care system" the above study reports.[12]



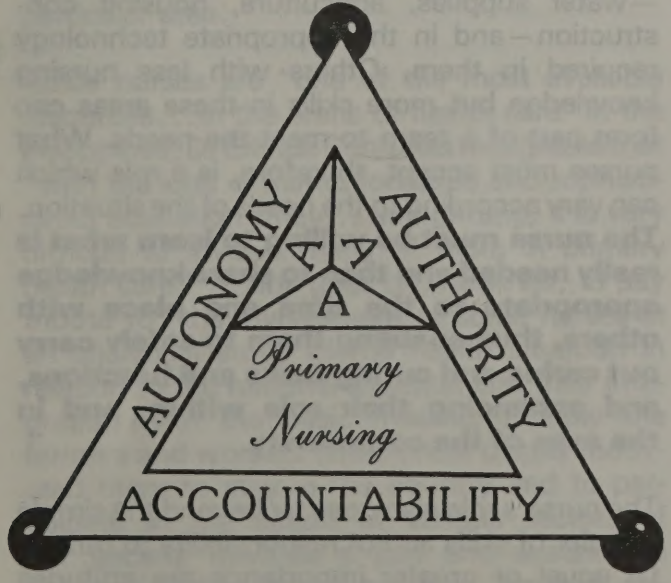
WHO photo
Nurse visiting a peasant home in Finland.

In one project cited in this study, the nurse is seen as fulfilling PHC functions by intervention in episodic incidents, by monitoring chronic cases and by promoting and maintaining health. The study also found that home visiting by primary care nurse practitioners helped decrease the need for hospital and other institutional care; the nurses were also able to identify early health problems which, had they been left unattended, might have led to more serious health problems and, eventually, to additional health care costs.

It should be stressed that the above statements refer to a society with well-developed medical and nursing services at all levels, where the point of first entry to the health care system — the "primary contact" — is considered to be via a doctor. The study and conclusions illustrate how the nurse can very well fulfil the functions and provide the care now thought to be the prerogative of the doctor.

Laing and Unsworth[13] describe primary nursing as encompassing "autonomy, authority and accountability". They use a triangle to illustrate this concept and envisage the primary care nurse as requiring educational preparation which will enable her* to function independently.

Their description of primary nursing in the Fort Murray Regional Hospital in Canada presents a picture in which the whole emphasis of institutional nursing is altered: patient education and increasingly individualized care are important aspects of the staff nurse's role. "Only registered nurses are used in implementing the concept... There are no team leaders... former head nurses are unit consultants who monitor quality control... each nurse becomes a bedside nurse directly involved, responsible for the total care of her patients. The primary nurse has the responsibility and accountability for planning the 24-hour care of her patient, from admission to discharge. She gives direct care where possible and, where direct care is not possible, she maintains close contact with the patient's family through her co-workers, known as associate nurses. The authority and accountability for total patient care rests with the primary nurse."[14]



* Since the advent of "modern" nursing in the West, the great majority of nurses have been women. However, in many Third World countries today, one is just as likely to find men as women practising as nurses.

If this ideal is realized in the countries utilizing primary nurses in this way, it is certain that a great deal will be done to restore the "caring" element to nursing. This concept of primary nursing, with clearly defined responsibilities and standards of preparation can, no doubt, succeed in areas where the requisite resources in personnel, facilities and funds are available. A question remains, however: what of the patient's involvement in his/her own health care? Is there a need to heed Miss Nightingale's warning on "being in the way" by trying to do too much for the patient rather than allowing and enabling him/her to make decisions and do such things for him/herself as he/she is able?

Health Care for All

Across the world or, possibly, on a native reservation not too far distant from the Canadian project cited above, or in other very rural or marginalized urban areas of developed countries, a completely different picture of health needs and the care required to meet them emerges. In developing countries or other regions where the number of prepared nurses of all categories is pitifully small in comparison to the needs, a complete reappraisal of *who* carries out the primary health care and *who* holds the responsibility for helping communities to take care of many of their own basic health needs is necessary.

Dr H. Mahler, Director-General of WHO, speaking of the need for primary health care workers to face the realities of the contemporary global health situation, has said: "The urgent health problems of the majority of people relate to poverty, to infection, to malnutrition and under-nutrition, to the lack of potable water and to multiple environmental hazards. History has shown that such basic threats to health as

these are unlikely to be countered by conventional health service techniques, however sensitively and intensively they may be applied by whatever category of health worker. If the needs of communities are to be met, the ranks of the health workers, including nurses and doctors, will need to consist predominantly of people who genuinely care about the health and welfare of impoverished communities, who are willing to learn what is to be done, and who can not only do it, but do it without dependence upon sophisticated and costly technology."[15]

The estimated number of trained nurses in the world is four million. Fifteen per cent of these are to be found in countries where 66% of the world's population live. Of that 15%, more than 5% will be found in urban areas and in institutions. Therefore, at present, a small handful of committed nursing practitioners are attempting to meet the vast health needs of the majority of the world's population and are really unable to cope adequately with these needs by virtue of their lack of appropriate preparation as well as number.

THE ROLE OF THE NURSE IN PRIMARY CARE

How can Primary Health Care bridge this gap? Does it mean larger numbers of prepared nursing personnel and trained auxiliaries? Where are these to be found, and at what cost? The trained professional nurse, whether the product of a three-year diploma course or a degree programme of greater length, has been hailed in a great many developing countries as the provider of quality nursing care to their people. In some instances, diploma programmes, barely established and not yet providing enough practitioners, are being replaced by degree programmes. Because of the length, cost and basic qualifications required for these, even fewer nurses can be produced, while the majority of the populations to be served live far from the centres where nurses thus prepared will work. Where medical institutions and facilities are situated in rural areas, services provided are inaccessible to the masses of the people because of their high cost and cultural unfamiliarity. Relatively few graduate nurses are available to work in such institutions, either to provide care directly (as in the type of primary nursing being carried out in the Fort Murray project cited earlier) or to supervise the larger number of auxiliary personnel of various grades who now commonly provide much of the nursing care in rural facilities.

Is the nurse's role in PHC restricted to training, supervision and ensuring quality care? This would very well match the professional standards for which nurses have been prepared over the past quarter-century or more. Who then determines the needs which PHC is attempting to address? Part of the nurse's role in PHC may also be to reexamine people's health needs as well as the causes of ill health. In this, nurses will need to be prepared to be the learners from teachers far less skilled and sophisticated than themselves. They will need to admit that the causes of ill health go beyond the bacteria they see under their microsopes and that the majority of them have their origins in such factors as poor housing and sanitation, lack of potable water, unemployment and lack of adequate food, among many others.

In determining the needs, nurses will have to admit their inability to meet the majority of them successfully, despite their higher level of learning. What are the answers to the thousand and one deficiencies in the everyday environment of people? Who takes care of a child's high fever in a rat-infested shack or, without a great deal of technology, successfully rehydrates a baby dying of the results of malnutrition and diarrhoea?

When the basic causes of health and ill health are determined, it becomes evident that even the best-prepared nurse has few skills and knowledge in the areas most often involved —water supplies, agriculture, housing construction—and in the appropriate technology required in them. Others with less nursing knowledge but more skills in these areas can form part of a team to meet the needs. What nurses must accept, therefore, is a role which can vary according to the needs of the situation. **The nurse must be willing to learn what is really needed and then to share knowledge appropriate to the time and place with others, thus enabling them to safely carry out caring and curing tasks and functions, and enhancing their role within, and in the eyes of the community.**

The nurse's role also goes far beyond the simple transfer of skills and of responsibility to others. Of equal or greater importance are attitudes and personal relationships between the nurse and the community. Pills and potions, treatment, advice, health education and training

WHO photo by J. Littlewood

Nurse discussing nutrition with a mother at a health post in Costa Rica.

and supervision of community people as village health workers so that they may look after the health needs of their families and communities — all will have little effect if the teacher is not accepted and trusted by the community as someone who cares and who understands them and their needs. Unless people feel that the nurse or caring person is prepared to discuss their own perceptions of their needs and, through dialogue, arrive at a mutually acceptable solution, treatment, advice and teaching will have very little long-term effect.

That there *is* a place for the nurse in Primary Health Care in both developing and developed countries has been clearly demonstrated by the dedicated few who have often been the ones to identify alternative forms of health care and, through example and teaching, have prepared other workers to meet the basic needs of a particular area.

While nurses are "one of the most available resources... in the arena of health care" in the Philippines, Dr Erlinda Senturias recognizes that "with the kind of institutionalized and sophisticated education (they)... are getting, it is very difficult to involve many of them in primary health care."[16] She goes on, however, to pay tribute to "the involvement of some nurses in an analytical study of the health situation in relation to the national situation and their integration with the basic masses, notably the farmers and workers (which has) deeply motivated them to stay in the country and to participate in the action of various sectors of our society towards a just and sustainable society."[16] She points out that "work in primary health care programmes has become more meaningful and productive with this kind of involvement and orientation."[16]

Dr Senturias goes on to describe (and prescribe) the role of such dedicated nurses in primary health care:

"1. To arouse people's awareness of, and interest in, health, particularly in measures that would promote their general well-being and wholeness.
2. To develop the capacities of the people to investigate and assess their health status, needs, resources inside and outside the community, the decision-making process, and how values, beliefs and knowledge are propagated in the community.
3. To equip the people in the community with appropriate health knowledge and health care competence to attend to common and simple medical conditions, with stress on the use of indigenous resources.
4. To develop and sharpen people's ability to analyse critically their problems and the processes involved in their solution so that they will always be conscious of their role in social transformation.
5. To enhance local initiative, leadership and cooperation in the solution of identified health needs and problems and to develop mechanisms whereby their efforts could be linked up with those of other community groups involved in health and other socially transforming programmes.
6. The primary health care nurse practitioner should link herself with the rest of the health professionals in order to continually sustain her in the work of social transformation."[16]

Dr Senturias concludes that "...every health worker involved in the popularization of primary health care should strive to solve the root causes of our health problems which means more than just the delivery of health care, but also the courage to participate in the restructuring of the total systems in our society."[16]

The attempt by the "dedicated few" to find and practise alternative forms of health care sometimes has meant utilizing traditional medical practitioners who, until then, had been largely ignored as a potential human health resource. Their skills and the people's confidence in them have been turned into an asset for the health team.

Eight years ago, a well-prepared, dedicated, missionary nurse found herself the only trained health person in a vast mountainous area in Cameroon, far from the reach of roads and served only by walking trails. The local population-

WHO photo by R. da Silva

Use of the flannelgraph to teach nutrition during training/refresher courses for midwives in Niger.

were widely scattered in family compounds and relied on traditional healers and birth attendants for care. The referral hospital for this area was five walking days aways and the nearest hospital was situated across the border in Nigeria, over two walking days away. Medical supplies arrived when possible by single-engined plane from the base hospital. The diseases and debilitating conditions common in such communities prevailed here. The two most prevalent causes of death were neonatal tetanus, which was traced to the bamboo knives used by the traditional birth attendants for a variety of purposes other than deliveries and were never washed, and a diarrhoea traceable to a herbal mixture given to children for coughs and colds by the traditional healers.

The nurse's dilemma was that, if she antagonized the healers to whom the population turned for care in the absence of medical and nursing professionals, not only would she run the risk of jeopardizing her own ability to work with the community but also, she would be forever alienating these potential human health resources.

With skill and ingenuity, the nurse set about winning the confidence of the people and their healers. During the initial stages of making contact, she asked for, and received, instruction in the local healing practices. This allowed her to determine helpful as well as harmful practices and permitted her to offer her help in the form of an exchange of knowledge. She gave simple instructions to the midwives on cleanliness, care of the newborn and alternative methods of cutting and dressing the cord and brought about a rapid drop in the incidence of tetanus. The diarrhoea-causing cough mixture was eliminated by offering the traditional healers a substitute composed of safe ingredients in exchange for their "recipe".

WHO/UNICEF photo by J. Ling

Traditional midwives run their own retraining courses beside their delivery hut in West Africa.

WHO photo by J. Littlewood

A nurse giving instructions on hygiene and use of a simple medical kit to a local midwife, Costa Rica.

Now, eight years later, the primary health care of the population, both preventive and curative, is being done by those who were there when the nurse arrived. They have become primary care workers whose service has been improved by her knowledge and skills. They teach prevention in their own language and style, but with knowledge which she has been able to pass on to them. While the roads are no better and the hospitals no nearer, methods of getting patients who need it to hospital who, previously, would have died, have been developed by the use of simple and appropriate technology, with the help of the people themselves. This way of work, while unconventional, has proved highly effective and suited to the needs of the particular community.

Is this kind of experience and response to needs replicable? The answer, in terms of PHC, must be: not entirely, since there are unique aspects to each community to be served. But definite lessons can be learned from this example of respect for people's ability to participate in their own health care, and from the methods employed for obtaining this level of participation.

PREPARATION FOR NURSING

For the nurses of today and tomorrow, preparation and continuing education are vital inasmuch as they help to prepare them for the widening horizons of a growing profession. If nurses' academic preparation makes them sensitive to people and their needs, including a respect for them as people, this is an asset. If, on the other hand, it increases their sense of professionalization and their own worth to the extent that anyone lesser prepared is considered "not competent", then it is of negative value.

Since primary health care will be different from one region to another according to the different climatic, economic, social and cultural conditions prevailing in each, the preparation of nurses for primary care will, likewise, need to vary according to the specific health needs. Marie-F. Collière, in speaking of the need to initiate nursing personnel to primary health care, states: "...it is necessary to prepare nurses to discover primary health care. This includes nurses working in the hospital setting and outside of hospitals, and nurse educators — who often teach things which they have never discovered, never seen. Plans must be drawn up to assist nurses in discovering different lifestyles, for it is these varied settings which provide the facts on which primary health care can be built. These settings include the family setting and the home; the work setting (men's work, women's work and children's work — the school); and other settings. Nurses should be prepared to work *with* the population and not *for* the population, as has been the case over the last decades... Nurses must learn how to listen to suggestions coming from groups; how to document their proposals; and how to work with other social models than those of employer/employee; care-giver/recipient of care. Nurses must be prepared to work with other health and social personnel... This means breaking the 'inferiority complex' of nurses and establishing reciprocal relationships with colleagues... Nurses must be prepared to develop primary health care, with priority accorded to the local level."[17]

WHO photo by Dr D. Anand

Nurse and health worker bring primary health care to the village in Papua New Guinea.

Nurses' preparation must enable them to be flexible and open, to see nursing as a caring, enabling profession, helping them to understand the realities that people come from, including the reality of the environment. The need for a realistic vision is illustrated by the tale of a nurse who, in a very arid region, told mothers to boil the water which their children drank, thus overlooking the scarcity or complete lack of fuel. How does the ingenuity and caring concern of the nurse come into play here to ensure safe water for the children? How have nurses been prepared to meet this kind of challenge?*

SUMMARY AND CONCLUSIONS

From earliest times, nursing as a caring art, science and/or vocation has been a part of people's lives, in sickness and in health. Nursing has been done by many kinds of people in different times and places throughout history. Whether or not they were prepared for this role and the kinds of preparation they received related to the different understandings of the role of nurse.

The evolution of the Western model of "modern" nursing in the 19th century and its transposition to other continents and regions with different concepts of what constitutes health, healing and sickness, and different needs, has been seen as a mixed blessing.

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*See CONTACT No. 52, August 1979, "Safe Water — Essential to Health".

The advantages of scientific nursing and the elevation of nursing to a respected profession often have been balanced by disadvantages. These have been related as much to the "training out" of the caring element (with increasing reliance on sophisticated technology, in an institutional setting) as to the insurmountable constraints to providing quality care to the vast majority of the world's population.

Primary Health Care as a possible means through which the caring aspect can be restored to nursing, and through which "Health for All" can become a reality, has been explored. The nurse's role in PHC is seen as being one of determining needs, relating to, and learning from, people, teaching and enabling them to be responsible for their own, their families' and their communities' health.

The struggle of the nursing profession in this century has been to reclaim the decision-making power to determine its own future. This battle has now, largely, been won. Today's nurses, wherever they live and work, face a challenge: that of being part of the team ensuring health care for all by the year 2000. In the challenge lies a dilemma:

Can they pursue a path of professional excellence through better and better education, and improve their professional image without losing touch with patients as people?

Can they admit that a person or a community can be involved in their own health care and can perform urgently-needed curative and preventive measures, independently of the nurse, without considering the person/community a threat to their professional standing?

WHO photo by J. Littlewood

The health team, Costa Rica: nurse, health workers, auxiliaries, midwife and cook.

Can knowledge be passed on to enable others to perform such tasks as nurses are unwilling or unable to perform for a variety of reasons without this being seen as weakening the nurses' professional status?

The question are numerous. But perhaps the essential one is: how can nursing best continue to grow as a caring, sharing profession, concerned with people and their needs, and find at the same time that this growth will be promoted by giving away some of the knowledge, skills and prerogatives of the profession to colleagues with lesser training and to the wider community as well? ■

The autor and the staff of the Christian Medical Commission would like to express their gratitude to the Discovery Foundation, a UK-based group whose aim is to encourage Christian work among nurses, for contributing to the production costs of this issue of CONTACT.

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References

1. Nightingale, Florence, **Notes on Nursing. What it is and what it is not.** Churchill Livingstone, Edinburgh/London/New York, 1980, p. 2.
2. Miller Ware, Alma, & Nofziger Chelgren, Mary, in **The Nursing Clinics of North America**, Vol. 6, No. 1, March 1971.
3. Skeet, Muriel, **Notes on Nursing. The science and the art.** Churchill Livingstone, Edinburgh/London/New York, 1980, p. 2.
4. Stanton, Margaret, "New Dimensions of Professional Responsibility", **International Nursing Review**, Vol. 26, No. 3, Issue 225, Geneva, May/June 1979, p. 84.
5. Collière, Marie-F., "Thoughts on Nursing Service and Identification of the Service Offered", **International Nursing Review**, Vol. 27, No. 3, Issue 231, Geneva, May/June 1980, p. 86.
6. Ibid., ref. 4.
7. Ibid., ref. 5.
8. WHO, July 1977 statement, cited in Collière paper, refs. 5 & 7.
9. **International Nursing Review**, Vol. 27, No. 2, Issue 230, "News" section, Geneva, March/April 1980, p. 40.
10. **International Nursing Review**, Vol. 27, No. 6, Issue 234, Geneva, November/December 1980.
11. Canadian Nurses' Association, **Putting "Health" into Health Care**. Submission to Health Services Review 1979. Ottawa, Ontario, February 1980, p. 3.

12. Ibid., p. 5.
13. Laing, B. & Unsworth, D., "Primary Nursing—What does it all mean?" **AARN Newsletter**, Vol. 36, No. 8, Alberta Association of Registered Nurses, Edmonton, Canada, September 1980, p. 1.
14. Ibid., pp. 2-3.
15. Mahler, Halfdan, "Action for Change in Nursing", **World Health**, WHO, Geneva, December 1978.
16. Senturias, Erlinda N., "The Role of Graduate Nurses in Primary Health Care", unpublished paper, 1980.
17. Collière, Marie-F., "Development of Primary Health Care", **International Nursing Review**, Vol. 27, No. 6, Issue 234, Geneva, November/December 1980, pp. 171-2.

Bibliography of Associated Reading

1. Barrow, R. Nita, "The Role of the Nurse in the Delivery of Health Care", **The Changing Roles and Education for Health Care Personnel Worldwide in View of the Increase of Basic Health Services**. Papers from a consultation sponsored by the Society for Health and Human Values, Bellagio, Italy, May 1977. Society for Health and Human Values, Philadelphia, 1978.
2. Canadian Nurses' Association, **Putting "Health" into Health Care.** Submission to Health Services Review 1979. Ottawa, Ontario, February 1980.
3. Fendrick, Richard A., "The Community Health Nurse and the Community Development Process". Master's project presented to Faculty of the University of Texas, Health Science Center, June 1974. (Unpublished).
4. **International Nursing Review**, International Council of Nurses, Geneva.
   Vol. 23, No. 6, Issue 210, November/December 1976
   Vol. 25, No. 5, Issue 221, September/October 1978
   Vol. 26, No. 3, Issue 225, May/June 1979
   Vol. 27, No. 1, Issue 229, January/February 1980
   Vol. 27, No. 2, Issue 230, March/April 1980
   Vol. 27, No. 3, Issue 231, May/June 1980
   Vol. 27, No. 4, Issue 232, July/August 1980
   Vol. 27, No. 6, Issue 234, November/December 1980
5. ISIS, "Women and Health—Part 2", **International Bulletin** No. 8, ISIS, Geneva, 1978.
6. Laing, B. & Unsworth, D., "Primary Nursing—What does it all Mean?" **AARN Newsletter**, Vol. 36, No. 8, Alberta Association of Registered Nurses, Edmonton, Canada, September 1980.
7. Meijin, A., Pizurki, H., & Royston, E., **Physician and Nurse Migration**, WHO, Geneva, 1979.
8. Nightingale, Florence, **Notes on Nursing. What it is and what it is not**, Churchill Livingston, Edinburgh/London/New York, 1980.
9. Senturias, Erlinda N., "The Role of Graduate Nurses in Primary Health Care", 1980 (Unpublished).
10. Skeet, Muriel, **Notes on Nursing. The science and the art.** Churchill Livingstone, Edinburgh/London/New York, 1980.
11. Taylor, John C., "Murri Doctor or Nursing Sister?" **The Aboriginal Health Worker**, Vol. 2, Nos. 1 & 2, Australia, March & June 1978.
12. Victorian Ministry of Immigration & Ethnic Affairs, **Cultural Awareness Course for Nurses**, course manual, Victoria, Australia, August 1979.
13. WHO, "Nursing personnel needed—but how many and where?" Working Group on Nursing/Midwifery in the Context of Health Care Delivery Systems, Brussels, December 1979. Press Release EURO/31/79, ICP/SPM 021.
14. WHO, "WHO Expert Committee on Nursing. Fifth Report", **WHO Technical Series**, No. 347, WHO, Geneva, 1966.
15. WHO/UNICEF, "International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978". Information bulletins nos. PHC/12, 13, 14, 15 & 16. WHO Geneva & UNICEF New York. September 1978.
16. WHO, "Nursing", **World Health,** Geneva, December 1978.
17. Roper, Nancy, Logan, Winifred W. & Tierney, Alison J., **The Elements of Nursing**, Churchill Livingstone, Longman Group, Harlow, Essex, UK 1980.

Southern Asia Regional Consultation on The Christian Understanding of Health, Healing and Wholeness

New Delhi, India, 25-29 August, 1980

Fourth in a series of regional consultations called by the CMC in the past two years, a meeting was held in New Delhi between 25-29 August, 1980 for the Southern Asia region. The previous three consultations, for the Caribbean, Central American and African regions were described in CONTACTs nos. 51 and 54. In keeping with the previous meetings, the theme of this consultation was "The Christian Understanding of Health, Healing and Wholeness". Each of the meetings contributed richly towards deepening understanding of this basic theme of the CMC Study/Enquiry.

The over-70 participants at Delhi were drawn from the Southern Asian countries of India, Sri Lanka, Nepal, Bangladesh and Pakistan and represented a wide range of interests and disciplines: pastors, doctors, theologians, nurses, psychiatrists, social workers, health educators, development workers, hospital administrators, government officers, national coordinators of church-related health services, community health workers, lay church workers, charismatic healers, practitioners of indigenous systems of medicine (Ayurveda, Unani, Yoga and Homeopathy). The participant group was very ecumenical in being composed of Protestants, Catholics, Hindus, Moslems, Humanists, Seventh-Day Adventists, etc. Also present were Dr Sylvia Talbot, moderator of CMC, Dr Martin Scheel, vice-moderator, CMC staff members Dr Stuart Kingma, Dr Eric Ram, Mr Victor Vaca and Ms Heidi Schweizer as well as several commissioners and friends from different continents who attended with the idea of sharing experiences from, and to, other regions.

For many, it was the first time they had come together with others from totally different backgrounds to reflect on and interpret the concepts of health, healing and wholeness within the sociocultural and religious context of the region. The consultation also provided an opportunity to make new contacts with neighbours and share each other's experiences and concerns.

The inaugural speech was made by Rev Zarine Rolston, General Secretary of the National Council of Churches of India. Rev Rolston introduced a number of issues confronting the church in carrying out its healing ministry. The participants identified several additional issues and formed five working groups to discuss these in detail. The topics thus identified were: "Church and Health", "Financing Community Health Programmes", "Development", "Human Values and Human Relationships" and "Charismatic Healing". Some of the highlights of the groups' reports are given below:

1. "Church and Health"

This group suggested an essential relationship between what the church is called to be, and the reality of alienation and ill health. The contemporary church is a valid embodiment of the struggle to attain the wholeness called for by Christ, using means available to it to promote healing in the world.

The church is a worshipping and witnessing congregation called to action in response to a need. Its purpose is to develop the potential of all persons, enabling them to fulfil God's purpose in creating them and restoring them and their communities to having right relationships (reconciliation). The role of the Christian is to create an environment (physical, social and spiritual) in which people may come to the fulness of life and respond to its diversity and multiplicity.

The group unanimously affirmed that church bodies should cooperate with people of other faiths in caring for health needs.

The population "to be served" by the church was identified as "the poor". In the context of health services, *the poor* are the masses suffering from diseases such as diarrhoea, malnutrition and infection which are predominantly due to unjust distribution of resources. To serve them, the church must join with others of goodwill to make poor people aware of their problems, to struggle with them in mobilizing and organizing themselves; to create public opinion in their favour and to work for government policy which promotes just distribution of

resources. Health ultimately depends on greater social justice, which would provide the climate in which the present maldistribution of health services can be rectified.

2. "Financing Community Health Programmes"

The group devoted much time to looking at the view, mentioned earlier in the meeting, that church-related, community-based primary health care programmes are expensive to run and a burden on the agencies and/or organizations responsible for them. It was said that an effort should be made in the direction of self-sufficiency since long-term external aid tended to make people dependent and stifle initiative. To this end, various forms of health insurance should be encouraged on the condition that they be adapted to local means and circumstances. Health programmes should be linked with socioeconomic ones which help people to become financially independent and, thus, pay for their own health care. Income-generating activities such as farming, fishing, poultry-raising, craft cooperatives, etc., can provide a financial base for community-based health care.

In reference to financial support, church-government relationships were discussed. It was said that, if church-related health programmes are to be more successful in contributing to the total PHC effort, new financial structures and a shift in government funding priorities in favour of PHC, are needed and should be encouraged. So far, if governments give subsidies to church-related health programmes, it is generally on a bed-grant basis. Little or no assistance is given for community health programmes except for vaccines in limited cases. All community health programmes should fit into the context of national health programmes and be carried out in close collaboration with government.

It was emphasized that one of the important ways to redirect health care and reduce cost is through emphasizing prevention, and promotion of good health. Efforts such as providing safe water, improving sanitation and promoting the use of local food resources in balancing the diet are important here. Another way to reduce costs is for church-related health programmes to make maximum use of vaccines and drugs available free from government and other organizations. The use of low- or no-cost, effective and easily-available indigenous herbs and medicinal plants was also suggested. Drugs should be sold and used by their generic names. Cost may be further reduced by using a limited number of essential drugs. "The church should stimulate the distribution and manufacture of low-cost drugs."

Health costs can also be lowered by good management and careful planning geared more towards the care of common illnesses and the use of inexpensive but effective appropriate technology. With this aim in mind, training programmes should be oriented towards village health workers and other community members, since a major percentage of illnesses occurring in the community can be taken care of by these people without the services of a doctor.

3. "Development"

This group understood "development" as "a dynamic process of change for the betterment of each individual, family, community or nation as a whole, including socioeconomic, structural and political change. The ultimate goal is a wholesome, healthy society in all aspects, namely, physical, mental, social and spiritual." The indicators of a healthy society were said to be harmony and peace with oneself, others, the environment and with God. Development should be done in partnership, with responsibility and love. Active participation of people and the community whom the development is to benefit in the process is a must. This can be achieved through people identifying their own needs, setting priorities, planning, implementing and evaluating their programme. Trust and confidence in the potential and capabilities of people in themselves and others must be built. It was also suggested that certain fundamental attitude changes on the part of policy makers are necessary; the church also needs to give priority to development and to needed internal structural changes.

3. "Human Values and Human Relations"

This group defined "health" as "a dynamic state of harmony between a person and his or her family, society, environment and God. Sickness should be viewed as a physical, emotional, spiritual, psychological and/or social disturbance." Every individual must be enabled to reach his or her optimum level of health. New ways of planning and implementing programmes, of training personnel to deal in a more honest way with local beliefs; and of reinforcing people's potential to recognize their own problems and find resources through their

own efforts must be found in order that this aim can be realized.

It was suggested that instruction in ethical and Christian values, counselling, interpersonal relationships and person growth should be included in the training of all levels of health staff, including medical and nursing students. The creation of a real team spirit could thus be fostered in which everyone's contribution would be given its due. Changes in the present curricula of medical and nursing schools which would make the training more relevant to the needs of the community, such as the teaching of human values, should be introduced.

The importance of the relations between health workers and patients was mentioned, since they play a key role in the process of healing. Anger, hate, condescension and even indifference can destroy the relationships and defeat the purpose of the healing effort. Factors such as physical structure of buildings, procedures and attitudes of staff, knowledge of the patient's family life — all influence relationships. The fears, anxiety and premonitions of patients are, for them, very real and medical staff need to be sensitive to these. The group was concerned with the general dehumanization of care at all levels. Churches and church-related agencies and institutions were encouraged by this group to deal creatively with the biomedical and ethical issues which are being raised by new health technologies.

5. **"Charismatic Healing"**

Charismatic healing was seen by this group as a gift of the Holy Spirit which is a part of the church's total healing ministry. The group reflected on the volume of evidence showing that various diseases medically diagnosed as incurable had been healed through prayer and laying on of hands and it was pointed out that charismatic healing lays no cost burden on the health system.

Until now, this form of healing has been preoccupied with healing individuals but an involvement in the ailments of society (which result in socioeconomic and political injustices) should not be excluded. Important as individual healing and wholeness are, they could be promoted within "systematic wholeness" by struggling against all forms of oppression, inequality and injustice in society.

Health, Healing and Wholeness — a Summary

After the group work, participants came together to share the insights they had gained on the overall topic of health, healing and wholeness. It was felt that the concept of wholeness is not alien to Asia but in fact characterizes much of what is known about family life and indigenous systems of healing in this region.

Health tends to be viewed as an integration of all aspects of the person in relation to the whole cosmos, and a fulfilment of one's potential for creativity; it can emerge when a person has been healed, forgiven or changed and is open to continuing growth. Healing may require some kind of enlightenment or inner conversion, and conveys a sense of peace.

Wholeness in the Asian context can best be described by listing some of its elements:

- It is an experience of "Shanti" in God.
- Forgiveness of sin and reconciliation with God are important steps in achieving wholeness.
- It means having a sense of belonging, being accepted, understood, cared for and comforted, being a part of the sharing of joys and sorrows.
- It is not limited to individuals, but extends to the family and community.
- In terms of joint family and community, wholeness means having "common wealth", sharing talents, gifts, love, joys, sorrows. This is disturbed when family relationships are broken by selfish actions.
- It means being "open", allowing oneself to be a part of the larger family, living with a sense of community, where justice for all prevails, where basic needs such as for food, water, clothing, shelter, education, employment, etc., are met, and where brokenness is restored.
- Relationships, "ruralness" and a sense of simplicity and inner peace are important.
- Wholeness also means having self-dignity and self-confidence.
- Persons with disabilities can also experience this same sense of wholeness. ■

Listed in the references and bibliography of the article on nursing is a two-volume set comprising Florence Nightingale's **Notes on Nursing. What it is and what it is not,** and Muriel Skeet's **Notes on Nursing. The science and the art**. While Miss Nightingale is renowned throughout the world for her work in establishing nursing as a respected profession, her writings are less known today. This is the first reprint of one of her most interesting works since its intitial printing in 1859. Her Notes were intended, as she explained, not as "a manual to teach nurses how to nurse. They are meant simply to give hints for thought to women who have personal charge of the health of others." Since "...every woman is a nurse, everyday sanitary knowledge, or the knowledge of nursing, or...how to put the constitution in such a state as that it will have no disease, or that it can recover from disease, takes a higher place." The extraordinary relevance of these Notes to nursing today will be evident to all who read this absorbing book.

In the companion volume, Muriel Skeet, a nurse with wide international experience, looks at the topics raised in the earlier work from the perspective of the 1980s. In a series of essays bearing the same titles as those used in the first Notes, Miss Skeet raises a number of contemporary and controversial issues. She encourages the reader to compare and contrast the problems she outlines with those originally described by Florence Nightingale.

Inquiries and requests for these books should be addressed to the publisher:

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How to look after a Refrigerator
by Jonathan Elford 1980 58 pages

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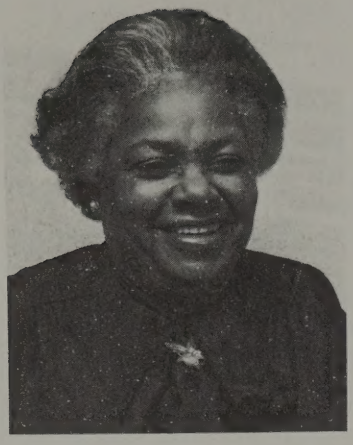
CMC NEWS

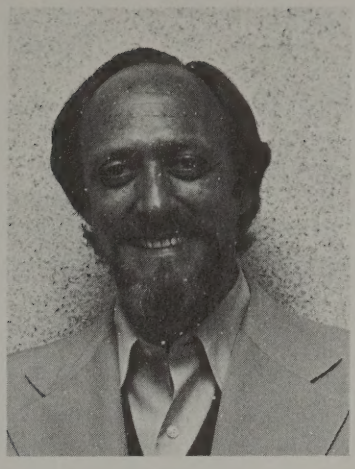
The year's end brings with it a number of imminent and actual changes in the composition of CMC's staff, following a period of stability. Nita Barrow submitted her resignation as Director to the WCC Central Committee in August 1980. Rosita Hernandez (Demaurex), who has held responsibility for the CONTACT mailing list, also announced her decision to return to her home country of Panama. Rosita joined CMC in March 1977 and has been greatly loved and appreciated by all her colleagues in the WCC for her warmth and gaiety, as well as for her contributions as a member of the CMC team. She takes with her the blessings of her many friends and the warm good wishes for her future life and work of her CMC colleagues.

Nita's decision to take her retirement — she will be returning to permanent residence in Barbados — came as something of a shock to many who had been hoping that her occasional hints about "going while still appreciated" and "time to move on" were simply her brand of dry humour. True, however, to her belief in the need for change and renewal — which has allowed many different institutions, organizations and groups to benefit from her unique talents, skills and qualities over the years — Nita resolved to leave CMC and Geneva before the end of the life of the present Commission. A feeling of desolation among staff, commissioners and friends quickly gave way to one of joy that, in the hands of its future Director Stuart Kingma, well-known to CMC's constituency as an Associate Director since 1975, continuity would be assured. Stuart's appointment was announced by the WCC Central Committee in August 1980, and he assumes his new position as of February 1981.

It is difficult to express CMC's deep gratitude to Nita for her inspiration and guidance in things large and small, for her vision of the Commission's role, for her unique way of relating to and with people and for her unwavering devotion to health and human development. Even her decision to leave reflects these qualities. A promise to stay in close touch with the work of the Commission as well as with commissioners and staff has been made. Nita was reelected to another term as President of the World YWCA so will be travelling to Geneva from time to time; since her interest and involvement in the fields of health, development, nursing and education is undiminished, friends and associates can hope to see her at international meetings, seminars and on field visits in the future.

Other staff changes marking the end of 1980 are either temporary or anticipated ones: Study Secretary Jeanne Nemec left Geneva in October 1980 for four months' leave of absence in the US; Trudy Schaefer ably replaces her for this period. Trudy herself plans to leave Geneva for Hong Kong and a new posting for her husband in June of next year. Two new staff members with secretarial and French-English language skills joined CMC in November 1980 to take over from Rosita and Trudy when they leave. Rosita hands over charge of the CONTACT mailing list to Fernande Chandrasekharan, who joins CMC on a half-time basis. Mireille Vautravers will be assisting her in this area and will also be assuming Trudy's secretarial duties. Mireille is of Swiss nationality but grew up in the US and graduated from Cornell University nursing school, and has worked as a graduate nurse since then. Mireille includes Spanish in her catalogue of language skills.





R. Nita BARROW was born in Barbados and received her nursing and midwifery training in the West Indies. Subsequently, she was awarded public health and nursing education diplomas from the University of Toronto, her Sister Tutor's Diploma from Edinburgh University, a BS degree from Columbia University, New York and an honorary Doctor of Laws from the University of the West Indies. Earlier this year, an Honorary Fellowship of the Royal College of Nurses of the United Kingdom was confered on Nita "in recognition of the contribution (she has) made to the advancement of the science and art of nursing and, in particular, in relation to the promotion and development of health care and education for the peoples of developing countries". In November 1980, Queen Elisabeth II made Nita a Dame of St. Andrew "for extraordinary and outstanding achievement and merit in service to Barbados and humanity at large" on the recommendation of the Prime Minister of Barbados.

From 1945-1954, Nita was responsible for developing and teaching in postgraduate public health nursing and basic nursing education programmes in Jamaica. From 1954-1956, she was Matron of the University Hospital, Jamaica. In 1956, she was appointed Principal Nursing Officer for the Government of Jamaica, a post she held until she was named Nursing Advisor for the WHO/PAHO, Zone 1 (Caribbean) in 1963. Nita has been a member of the CMC from its beginning, and joined the staff as an Associate Director in 1972; she was named Director in June 1976 and, in this position, guided the destinies of the Commission for a period of four and a half years while concurrently serving as President of the World YWCA, a post she continues to hold for the next four years. Her retirement at the end of this year will free Nita to pursue further her active involvement in many groups concerned with health, nursing and women's affairs.

Stuart J. KINGMA, MD, was born in the USA and received his medical education at Cornell University Medical College in New York. He completed his surgical training at the Henry Ford Hospital in Detroit, Michigan, and is a diplomate of the American Board of Surgery. With his wife, Joan, and daughter, Hope, Stuart served in Nigeria at a rural mission hospital for the Sudan United Mission during two periods, 1961-1967 and 1972-1974. During this time he shared in the development of an extensive rural health programme which emphasizes the training of several categories of community health workers and the full participation of the people of the community in the management of the work.

Stuart came to the CMC at the beginning of 1975 as Associate Director. Soon after his arrival, he assumed certain editorial responsibilities for CMC's publication CONTACT and he has retained these up to the present. He has participated in the full range of CMC activities and has travelled extensively, particularly in Asia and Africa, for the purposes of consultation, evaluation and conferences. For one year he was medical advisor for the World Council of Churches/Christian Conference of Asia Relief Programme in Kampuchea. His appointment as Director of the CMC will ensure a large measure of continuity in the concerns and activities of the CMC.

CONTACT is the periodical bulletin of the Christian Medical Commission, a sub-unit of the World Council of Churches. It is published six times a year and appears in four language versions: English, French, Spanish and Portuguese. Present circulation is in excess of 15,000. The papers presented in CONTACT deal with varied aspects of the Christian communities' involvement in health, and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development.

The editorial committee for CONTACT consists of: Stuart Kingma, Director and Editor, Miriam Reidy, Editorial Assistant and Heidi Schweizer, Administrative Assistant. The rest of CMC staff also participate actively in choosing topics for emphasis and the development of materials: Eric Ram, Associate Director (special portfolio: Family Health), Jeanne Nemec, Secretary for Studies, Trudy Schaefer, Secretary for Documentation and Victor Vaca, Consultant. Fernande Chandrasekharan, Secretary, is responsible for the CONTACT mailing list, assisted by Mireille Vautravers, Secretary. CONTACT is printed by Imprimerie Arduino, 1224 Chêne-Bougeries/Geneva, Switzerland.

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Certain back issues are available on request. A complete list of these is published regularly and appears in the first issue of each year in each language version.